Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Kevin A Williams

Respondent Name
Liberty Mutual

MFDR Tracking Number
M4-14-2049-01

Carrier's Austin Representative
Box Number 01

MFDR Date Received
March 11, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting for a Medical Fee dispute for the unlisted procedure code of 29999. We feel we were underpaid for this procedure… "

Amount in Dispute: $3,000.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgment of medical fee dispute received however, no position statement received.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 15, 2013	29999	$3,000.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out reimbursement guidelines for professional medical services.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - X901 – Documentation does not support level of service billed
   - W3 – Additional payment made on appeal/reconsideration
   - U849 – This multiple procedure was reduced 50 percent according to fee schedule

Issues

1. Did the requestor support the services as submitted?
2. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on March 11, 2014. Per 28 Texas Administrative Code §133.307(d)(1), "The response will be deemed timely if received by the division via mail service, personal delivery, or facsimile within 14 calendar days after the date the respondent received the copy of the requestor's dispute. If the division does not receive the response information within 14 calendar days of the dispute notification, then the division may base its decision on the available information." The insurance carrier did not submit any response for consideration in this dispute. Accordingly, this decision is based on the information available at the time of review.

2. 28 Texas Labor Code §134.203 (c) states, "To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications. (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (yearly conversion factor for date of service). For Surgery when performed in a facility setting, the established conversion factor to be applied is (yearly conversion factor for date of service).
    - Procedure code 29999, service date November 15, 2013, has a status indicator of C, which denotes services for which payment amounts are established on an individual case basis upon review of documentation. CMS does not determine a price or relative value for these services. If reimbursement is justified, these services are paid at a fair and reasonable rate. This code is not assigned a relative value or payment amount. Per §134.203(f), reimbursement is provided in accordance with 28 Texas Administrative Code §134.1 regarding fair and reasonable reimbursement. The insurance carrier allowed $512.66. Review of the submitted information finds insufficient documentation to support a different reimbursement amount from the amount determined by the carrier, therefore no additional payment is recommended.
3. Per applicable rules and fee guidelines no additional payment can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	December , 2014 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.